

HEALTH CARE PROVIDER REPORT OF STUDENT'S DENTAL EXAMINATION
School District of Reedsburg

Student/Estudiante: _____ M F Birthdate/Fecha de Nacimiento: _____

School/Escuela: _____

Parent/Padres: _____ Phone/Teléfono: _____

Complete Address/Dirección Completa: _____

This child has been seen for a dental examination with the following results:

_____ Child is involved in a preventive dental program

_____ All necessary dental work has been completed

_____ Treatment is in progress

_____ No dental work is necessary

Signature/Title of Health Examiner: _____ Date: _____

Printed or Typed Name of Examiner: _____

Address of Examiner: _____ Phone Number: _____